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## Exploring Art Therapy with Clients suffering from Eating Disorders in an Out-Patient Setting

Miranda Hays  
mhays@lesley.edu

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Exploring Art Therapy with Clients suffering from Eating Disorders in an Out-Patient Setting

Capstone Thesis

Lesley University

May 2021

Miranda Hays

Specialization: Art Therapy

Thesis Instructor: Raquel Stephenson, Ph. D., ATR-BC, LCAT

### **Abstract**

To date no peer reviewed literature has been published using art therapy for the treatment of clients with eating disorders (EDs) in an outpatient treatment setting. Despite evidence-based treatment methods being used to help treat clients with EDs high rates of mortality and relapse persist for clients with EDs (Belak, 2017, p.1). There is a need for creative approaches to ED treatment that can be used to enhance existing evidence-based treatment models. Art Therapy can provide clients with EDs the opportunity to engage in the creative process which allows them to momentarily lessen their defense mechanisms and explore their ED behaviors (Bucharová, 2020). Through the use of art making clients with EDs are able to feel their feelings rather than just explaining their feelings that traditional talk therapy alone often provides (Wolf et. al., 1985). To expand upon current research and contribute to the field's current understanding, this writer designed and implemented a virtual 4-week peer support group for clients with EDs using evidence-based treatment methods and art therapy. This virtual Holiday drop-in peer support group was implemented in an outpatient ED treatment setting for individuals who are 18+ with an eating disorder. The client's thoughtful participation and positive responses to the art therapy interventions, suggests that clients with EDs, specifically those with AN, BN, OSFED, can benefit from art therapy and supports the need for further research.

## **Exploring Art Therapy with Clients suffering from Eating Disorders in an Out-patient Setting**

### **Introduction**

This review will highlight the current literature as it relates to the effectiveness of using art therapy with clients suffering from eating disorders (ED) in an out-patient therapy setting. I became interested in this topic during my time as a mental health counseling and art therapy intern at an out-patient ED clinic. During her time as an intern she identified a gap in treatment progression between using talk therapy alone with clients and incorporating art therapy interventions into her work with clients. This writer began to notice the process of building rapport with clients increased through the use of art therapy. Additionally her clients willingness to tolerate and share difficult emotions increased through the use of art therapy. She also came to realize that no standardized treatment method for using art therapy with clients with EDs existed. Any research that was available often consisted of mainly narrative depictions of client case studies (p. 138). Based on this writer's review of current eating disorder literature no studies to date have researched the use of art therapy for the treatment of EDs in an outpatient treatment setting.

It soon became clear to this writer that developing a method that used art therapy in the treatment of clients with EDs was needed. Therefore this writer and another intern developed a virtual four-week peer support groups using evidence-based ED treatment practices through the lens of art therapy. These groups were not designed to be an immediate fix for clients, but to offer temporary psychological relief in the moment and to support existing evidence-based treatment that some participants may have been receiving in individual therapy or other out patient mental health resources. The facilitators of this four groups integrated common themes and interventions



used in evidence-based ED treatment and integrated these treatment approaches with art therapy interventions. The hope was for clients to experience temporary psychological relief and to be exposed to new ideas related to their ED recovery through the use of art therapy.

## **Literature Review**

### **Eating Disorders Diagnoses**

According to the National Eating Disorder Association (NEDA) EDs are a life threatening mental and physical illness that affects people of all genders, ages, races, ethnicities, sexual orientations, bodies and weights (National Eating Disorders, n.d.). Based on national surveys NEDA suggests that an estimated 20 million people in the United States will experience an ED during their lifetime (National Eating Disorders, n.d.). For the purposes of this thesis the primary ED diagnoses that will be addressed and referenced are Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), and Other Specified Feeding or Eating Disorder (OSFED). It should be noted that these EDs are not representative of all the feeding and EDs included in the DSM-5. In this thesis proposal the term ED will be in reference to AN, BN, and BED. These ED diagnoses were the primary diagnoses that the writer worked with in the outpatient eating disorder treatment setting mentioned.

The DSM-5 characterizes Feeding and Eating Disorders as having “a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning” (American Psychiatric Association, 2013, p. 329). AN has been recognized for about 200 years (Morrison, 2014). The three main components of AN are that the client intentionally restricts their food intake causing significant reduction in their body mass, while remaining preoccupied with concern for weight gain, and a belief that they are currently overweight (Morrison, 2014).

Additional symptoms of AN can include intentional food restriction, over exercise, and vomiting or other purging behaviors (Morrison, 2014). According to Morrison (2014) BN is more common than AN. BN is characterized by a person feeling a loss of control over their eating habits, consuming food past the point of fullness one or more times per week and purging their food through vomiting after a binge which is typically followed by a period of restriction (p. 282). A client with BN may also engage in excessive exercise, or abuse laxatives or other drugs to manipulate their weight (Morrison, 2014). BED is the most common eating disorder diagnosis, affecting female identifying individuals twice as often as individuals who identify as male (Morrison, 2014). Nearly 2% of adults and about half as many adolescents will meet the DSM criteria for BED in their lifetime (Morrison, 2014). The overall prevalence rate among women, men, trans-gender, and non-binary individuals with BED may be significantly higher than reported due to the sense of shame and isolation associated with BED behaviors. BED is characterized by a client feeling a lack control, engaging in one or more binges per week where the client may eat too fast, eating to the point of physical discomfort and in the absence of hunger. Typically, bingeing can cause a client a sense of guilt and the client overtime may avoid eating around others for fear of embarrassment (Morrison, 2014, p. 285). A client with BED does not engage in purging behaviors or over exercise to “make up for overeating” (Morrison, 2014, p. 285). OSFED applies to presentations of feeding and EDs that cause a client “clinically significant distress or impairment in social, occupational, or other important areas of functioning” but the client does not meet the full criteria for any of the other feeding or EDs (American Psychiatric Association, 2013, p. 353).

Mental health diagnoses that commonly co-occur with AN, BN, BED, and OSFED include bipolar disorder, depressive disorders, anxiety disorders, and obsessive-compulsive

disorders (American Psychiatric Association, 2013). The high frequency of these diagnoses co-occurring with an ED diagnosis also impacts treatment approaches. Common struggles that clients with an ED may experience include perfectionism, control issues, shame, isolation, and body image concerns. It should be noted that this is not an exhaustive list but includes common struggles that this writer observed from the clients that the mentioned outpatient ED treatment setting served.

### **Out-Patient Eating Disorder Treatment**

While clinicians may choose to use a variety of theoretical approaches and modalities when treating clients with EDs evidence-based methods are the most widely documented, encouraged, and accepted methods for treatment (Becker, 2016). Becker et. al. (2016) suggests that there are three components to evidence-based practice in ED treatment: “research evidence, clinical expertise, and the [clients] values, preferences, and characteristics” (p. 1). Previously named the ‘three-legged stool’ by Sackett et. al. in 1996, all three of these components are seen as being essential to the treatment of clients with EDs (Becker et. al., 2016). Each leg of the stool could be used on its own when treating clients but are most effective when used together.

**Research Evidence.** The research evidence leg of the stool is concerned with a clinician using the most up to date and effective treatment methods for their work with clients. For example, Becker et. al. (2016) suggests that a clinician should be selecting their treatment approaches based on previous valid research such as studies using random controlled trials, meta-analyses, systematic reviews, case studies, and so on. The purpose of a clinician using treatment approaches that have been efficacy investigated minimizes clinical bias and ensures that the client will receive the most effective treatment based on current research for their treatment needs (Becker et. al., 2016).

Bucharová et al. (2020) suggest that EDs are one of the most challenging psychiatric disorders to treat therefore a large variety of therapeutic treatment approaches are used and emphasis is placed on the therapeutic alliance between the therapist and client. The most widely used ED treatment approach is Cognitive Behavioral Therapy (CBT) and its various forms such as Enhanced Cognitive Behavioral Therapy (CBT-E). Additional treatment approaches include Cognitive Remediation Therapy (CRT), Maudsley Anorexia Nervosa Treatment for adults (MANTRA), Specialist Supportive Clinical Management (SSCM), Focal Psychodynamic Therapy (FPT), Internal Family Systems (IFS), Dialectical Behavior Therapy (DBT), and Family-based approach for adolescents with EDs (Bucharová et al., 2020). While medication is not used as sole treatment for ED diagnoses, pharmacology is frequently used in combination with CBT or other psychotherapy treatment approaches. (Bucharová et al., 2020). Common medication used include anti-anxiety medications and anti-depressants. For the purposes of this thesis and the short term nature of the program implemented, the evidence-based treatment approaches that will be discussed are CBT, CBT-E, and DBT. These theoretical approaches were chosen based on the structure of CBT, CBT-E, and DBT's treatment models to elicit cognitive and behavioral change in clients with EDs.

According to Waller et. al. (2018) previous clinical trials indicate that for nonunderweight clients with EDs the use of CBT as a treatment approach led to approximately 40-50% of clients recovering with sustained long-term maintenance. CBT relevant to the treatment of eating disorders is typically structured, protocol-based and has a strong focus on behavior change specifically around eating (Waller et. al., 2018). A downside of using traditional CBT with clients with EDs is that this approach is demanding of resources, expensive to deliver, increases length of treatment, and typically requires clinicians to have specialized training

(Waller et. al., 2018). Waller et. al., 2018 proposes the use of a condensed version of CBT focused therapy that uses the “key active elements” of CBT (Waller et. al., 2018, p. 263). This condensed CBT approach takes about 10 sessions than compared to the traditional 20-40 sessions and requires less specialized training of clinicians (Waller et. al., 2018). This condensed version of CBT focuses on the here-and-now and maintenance cycles on the client’s ED and not their past experiences that may have led to the development of their ED. Some of the main tasks of Waller et. al. approach to CBT included monitoring the clients weekly caloric intake and weight, a here and now perspective, emphasizing behavior change early in treatment to restore the clients nutritional needs, addressing the clients cognitive distortions, exploring the impact of a clients biopsychosocial history on the development and maintaining factors of their ED, body image concerns and treatment planning (Waller et. al., 2018). Overall, there is a strong focus placed on maintaining the client’s safety, development of the therapeutic relationship, and initiating motivation to change within the client, and to help the client to develop a sense of agency (Waller et. al., 2018). These short term goals of using CBT with clients with ED were used to help develop the content of the four week virtual peer support group implemented in this thesis. Additionally, these short term goals could be more deeply explored through the use of art therapy interventions.

CBT-E is used to target the maintaining factors of a clients eating disorder (Fursland, 2012). These maintaining factors are identified through the case formulation done on that particular client and the specific cognitions and ED behaviors that client experiences (Fursland, 2012). Many clients with EDs can identify the negatives effects of their ED during the time of their intake such as their preoccupation with weight, shape, and food (Fursland, 2012). While, simultaneously believing that their ED behaviors are helping them to maintain their current

weight and prevent future weight gain. According to Fursland, working with this ambivalence is a huge part of the ED treatment process for the client. The therapist must work with this theme of ambivalence to help the client to decrease their fear around weight, shape, and food while increasing the client's motivation and courage to change (Fursland, 2012). The role of the therapist is to be validating of the disordered behaviors in the client's life while also "advocating [for] the need for change" in the client's life (Fursland, 2012, p. 322). Fursland highlights that the therapist must balance being respectful and empathic towards the client while remaining firm with the client about treatment expectations and boundaries due to the medical complications that accompany an ED diagnosis. While this treatment approach can feel challenging treatment goals should be created in collaboration with the client to mitigate the client feeling disempowered or misunderstood. Part of the initial stages of the CBT-E treatment process is that the clinician must help their client to understand the importance of them stepping outside their comfort, sitting in their discomfort, tolerating their discomfort for long enough to create change and get to a place of healing where the client no longer feels preoccupied with ED thoughts and behaviors. (Fursland, 2012). CBT-E requires the client to be an active participant in their therapeutic process and strongly focuses on the present (Fursland, 2012). According to Fursland, while certain past events of a client's life that led to the development of their ED may be interesting to explore in the therapeutic process, exploration of the past is usually not necessary in order for the treatment to be effective (Fursland, 2012). Therefore, similar to traditional CBT the main focus of CBT-E is on treating the present factors that are causing the client ED behaviors to persist.

Originally created for clients with borderline personality disorder by Marsha Linehan, DBT is a multidisciplinary treatment approach designed to reduce client's suicidal ideation and

self-injuries behaviors (Moonshine & Schaefer, 2019). DBT is used to teach clients how to increase their current levels of functioning, minimize current difficulties and stressors, and help manage future problems that the client might encounter (Moonshine & Schaefer, 2019). DBT uses CBT treatment strategies like psychoeducation, thought stopping, behavioral activation, reinforcement strategies, and extinction (Moonshine & Schaefer, 2019). In addition to these treatment approaches, DBT uses Person-Centered Therapy treatment approaches such as unconditional positive regard and validation strategies which emphasizes a focus on acceptance and change (Moonshine & Schaefer, 2019).

**Clinical Expertise.** The clinical expertise leg of the stool is concerned with a clinician's competence in understanding the basic skills of clinical practice, such as assessment skills, conceptualizing the biopsychosocial history of client, and determining the best treatment plan and theoretical approaches for a particular client. A clinician's level of expertise helps them to determine what evidence-based treatment methods are the best fit for a client's diagnosis (Becker et. al., 2016). In the process of this decision a clinician working from a person-centered orientation would consider the influence that a client's values and preferences would have on their treatment (Becker et. al., 2016). Therefore, clinical expertise is complex, requires ongoing training, education, on the job experience, and is ever evolving (Becker et. al., 2016). Based on the brief literature reviewed of CBT and DBT appropriate interventions that a clinician could use from these theoretical approaches when developing a short term ED peer support group include; psychoeducation, coping skills, mindfulness, and art therapy. Each of these treatment interventions address and support clients in achieving short term goals of their ED recovery.

**Psychoeducation.** Specific CBT based techniques such as psychoeducation can be used as a tool to help clients challenge their ED thoughts, increase their motivation to change their ED

behaviors, and work towards ED recovery (Belak, 2017). While psychoeducation alone cannot help a client with an ED fully recover, psychoeducation can be used in conjunction with other treatment methods. According to Belak, psychoeducation has been an effective treatment intervention for adult clients with BN and AN. Psychoeducation provides the client with information about their mental health diagnosis to help them understand their maladaptive coping strategies and how their maladaptive behaviors feed into the cycle of their eating disorder (Belak, 2017). Therefore, psychoeducation is a common intervention used in inpatient and partial hospitalization programs for treating EDs to better understand their behaviors.

**Coping Skills.** Hernando et al. (2019) highlights that ED behaviors are maintained through an individual's use of dysfunctional coping strategies, such as ruminating thought patterns. A person is considered to be experiencing ruminating thought patterns when they become repeatedly focused on their negative emotional states and their outcomes (Hernando et al., 2019). Offering clients alternative strategies for managing difficult emotions through the use of coping skills can help clients with EDs better regulate and tolerate their negative emotional states (Hernando et al., 2019). Providing clients with alternative strategies for experiencing their difficult emotions such as the coping skill of dis-identification can help clients with EDs decrease their use of rumination (Hernando et al., 2019). For example, if a client is feeling unworthy they might identify with that unworthiness and think to themselves "I am unworthy" and not worthy of others' kindness, love, and respect. If they practice dis-identifying from that feeling of unworthiness, they can identify while they feel unworthy in the present moment, they are also capable of feeling and thinking other things as well. Therefore, they can intentionally choose to acknowledge their limiting belief while also identifying with their strengths. Hernando suggests that dis-identification helps to teach a client with an ED a new approach for responding



to events, which overtime with practice can help prevent a client from further developing or maintaining the negative psychological outcomes of their ED (Hernando et al., 2019).

**Mindfulness.** Vanzhula (2020) presents a rationale for how and why mindfulness based techniques can be helpful for clients in ED treatment. Vanzhula suggests that given the success of Mindfulness-based cognitive therapy (MBCT) for the treatment of depression and anxiety, MBCT may be a viable option for treating ED because they are characterized by similar traits. Kabat-Zinn introduced mindfulness to psychology and defined mindfulness as “paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally” (Vanzhula, 2020, p. 2). While the majority of ED research using Mindfulness Based Programs (MBP) has focused on the use of mindfulness-based techniques for the treatment of BED MBT can be beneficial for clients with other ED diagnoses (Vanzhula, 2020). According to Vanzhula, MBPs were found to significantly reduce the rate of binge eating episodes for clients, decrease their overall binge eating symptoms and general ED symptoms (i.e. body shape and size, restriction behaviors, body dissatisfaction, and fear of weight gain). In addition to this symptom reduction previous studies suggest that using MBP can help to increase an individual’s psychological flexibility and self-compassion (Vanzhula, 2020). Both of which are helpful skills for individuals with EDs to develop as they navigate the challenges of ED recovery (i.e. potential changes in body size, grieving the loss of diet culture, etc.) While further research is needed, Vanzhula suggests that MBTs lead to the reduction of repetitive negative thinking (i.e. rumination and worry), increase self-compassion, increase de-centering, increase psychological flexibility, increase emotion regulation skills, and help foster awareness of hunger and fullness cues for clients with EDs (Vanzhula, 2020).

**Client’s values and perspectives.** Becker et. al. (2016) identifies that within the field of

mental health, researchers refer to client values and perspectives as preferences and expectations. For example, a client's preferences in the therapeutic relationship may pertain to the theoretical orientation they gravitate towards, their preference on the use of medication, length/frequency of treatment, treatment expectations, gender of the therapist, and so on (p. 5). Becker et. al. (2016) highlights that paying attention to the preferences and expectations of clients with EDs is so important because of documented high rates of treatment dropout by clients with EDs (p. 5). According to previous research using non-ED client samples, treatment dropout rates were lower, and outcomes were improved for clients who felt their preferences were matched during their treatment process. Previous data also supports an association between a client's expectations and treatment outcome. Becker et. al. (2016) suggests that previous research shows that clients who expect to do well during treatment are more likely to benefit from treatment than clients with lower expectations (p. 5). A client's preferences and expectations have a significant impact of their ED treatment because they both influence a client's expectation for treatment outcome and their decision to drop out of treatment (p. 5). While evidence-based treatment approaches have shown to help clients with EDs achieve full ED recovery, previous research has shown that between 35-41% of clients with AN relapsed within an 18-month period (Berends et. al., 2016). Given this significant rate of relapse for clients with AN additional treatment approaches seem to be needed in order to decrease the rate of relapse for clients with EDs.

### **Using Art Therapy with Clients with Eating Disorders**

Belak (2017) identifies that the rate of death and relapse for clients with EDs has significantly increased therefore the effectiveness of current evidence-based treatment methods need to be reevaluated and alternative treatment approaches need to be researched. One of these alternative treatment approaches would be to include art therapy interventions into the treatment

plan for clients with EDs. While the literature has shown traditional talk therapy can be used successfully to help a client with ED recover many clients still engage in therapy interfering behaviors, are resistant to treatment, drop out of treatment completely or relapse (Belak, 2017). Initial research suggests that including art therapy into a clients treatment plan allows them to experience additional therapeutic benefits that only the creative process can elicit. Previous research has shown, that overtime clients using art materials within the context of art therapy interventions can decrease their defense mechanisms, allow them to feeling their feelings, increase their self awareness and bodily awareness in a less threatening way and places value on their strengths and positive qualities to promote healing and empowerment (Belak, 2017).

Simply put, art therapy uses the creative arts such as drawing, movement, music, and drama to elicit and prompt healing for clients (Frisch et. al., 2006). Art therapy places value on a client's creativity, non-verbal forms of communication, their use of imagery, symbolism, and metaphor within their creative process and how these components may relate to their psyche and inner emotional experience (Bucharová, 2020). Art therapists honor the client's need to work in a contained therapeutic space that is safe and that incorporates art-based interventions that follow the client's unique treatment plan and needs (Bucharová, 2020). Previous research suggests that using specific art therapy interventions with clients with EDs is recommended to circumvent clients from acting out through their art materials and engaging in destructive regression (Hinz, 2006). Hinz (2006) suggests that working within the structure of a particular art therapy intervention helps the client to engage in information processing on a cognitive level while simultaneously creating a physically object that can be used to work through their identified challenges. When a client engages in their creative process through art therapy, they are using their 'right brain' which allows the client to shift from explaining their feelings to feeling their

feelings (Bucharová, 2020). For clients with EDs the creative process allows them to safely reconnect with parts of their body and how they experience emotions physically (Bucharová, 2020, p. 4). Therefore, for a client with an ED engaging in mindfulness-based practices that safely encourage them to be present in their body and build self-awareness around bodily sensations can promote healing overtime.

Bucharová (2020) suggests that the non-verbal aspects of the creative process can allow clients with EDs to momentarily lessen their defense mechanisms of rationalization, intellectualization, and persuasion all of which commonly occur for clients with EDs when they discuss their feelings verbally (Bucharová, 2020). A client may use these defense mechanisms to protect their sense of self and offer them a sense of control during traditional talk therapy which can slow the therapeutic process and prevent the client from being able to process their difficult emotions (Bucharová, 2020). The use of these defense mechanisms is common with a client with an ED because they use these defense mechanisms when discussing with friends and family about topics related to food intake, exercise, disordered eating behaviors, and body image (Hinz, 2006). Clients with EDs may often try to be resistant to therapy and the therapeutic relationship by defending their food and weight preferences, art making can help to redirect the client back to relevant issues of the therapeutic process. (Hinz, 2006). This redirection through the use of art materials allows the client to identify the core issues that are causing them to use their ED behaviors.

Wolf et. al. (1985) presents an illustrative case study of using art therapy in addition to evidence-based treatment methods for four clients with AN. Wolf et. al. highlights that while their clients often struggled to describe their inner emotional state verbally, they were often able to create “strikingly evocative illustrations in their artwork” (p.196). In their clients’ image’s

common themes that were identified included “the distorted, deformed self; the inner sense of emptiness and loneliness, and the anxiety over control and boundaries” (p. 196). All of these themes directly relate to issues that clients with AN struggle with. Wolf et. al. found that art therapy interventions helped the client to identify specific issues and conflicts they were dealing with and the specific defenses they were using to manage their conflicts. Unlike words that a client might articulate about their lived experience, art does not disappear (Wolf et. al.). The client is able to tangibly see, hold, and identify the feelings or emotions they have created in their piece of artwork. Wolf et. al. argues that a client’s artwork may express what their words alone are unable to describe (p. 198).

Hinz (2006) identifies that art often inspires universal themes of healing causing a shift to be placed on the client’s strengths and positive qualities as opposed to their ED behavior use. Art therapy can be a useful intervention in combination with other evidence-based treatment methods for clients with EDs because art therapy offers clients another medium for identifying and exploring their inner world in a less threatening way. For a client with an ED their ED behaviors can become apart their identity and the recovery process can feel extremely threatening to the clients inner ED voice because recovery means letting go of these behaviors. As mentioned previously, using art helps clients with EDs to identify their feelings, and feeling their feelings in a less threatening way.

### **Method**

This four-week virtual Holiday art therapy peer support group was implemented with individuals 18 years or older with mixed symptom EDs through the following methods. These groups were created out of an expressed need from the eating disorder community. Typically during the holiday season less groups are offered and clients out patient teams may be taking

time off to spend with their loved ones. Arguably the most challenging time of year for a client with an ED is typically the time when they have access to the least resources. In addition to those stated reasons, these groups also seemed even more needed due to increased isolation and decreased access to affordable and safe care that individuals could receive due to the Covid-19 pandemic. For the purposes of this paper the facilitators refers to the art therapy intern and the social work intern who led the four-week virtual groups. These facilitators wanted to offer a safe space for people 18+ to connect with others in ED recovery and to create art in community. The facilitators wanted to create a safe space for participants to create artwork that explores their inner and lived experiences while also providing participants with practical skills to navigate the holiday season that can be incredibly triggering and challenging for clients with ED.

This 4 week peer support groups incorporated aspects of evidence-based eating disorder treatment to expose clients to themes and concepts to either elicit their eating disorder treatment or support their current treatment. These groups were not designed to be an immediate fix for clients, but to offer temporary psychological relief in the moment and to support existing evidence-based treatment that some participants may have been receiving in individual therapy or other outpatient mental health resources. The facilitators of these four groups integrated common themes and interventions used in evidence-based eating disorder treatment and integrated these treatment approaches with art therapy interventions. The short term goals of these groups were for participants to increase their coping skills, self awareness, self esteem, decrease participants sense of isolation, build community and connection among participants.

### **Participants**

This Holiday drop-in peer support group was implemented in an Outpatient Eating Disorder Treatment Clinic for individuals who are 18+ with either AN, BN, or BED. Created as

an art-based peer support group, a total of 36 clients over the course of four groups participated. The total number of clients in attendance per group varied from 6-16 clients.

### **Materials**

All participants were made aware of a required art supply list when signing up for the group. All participants were emailed a HIPPA-compliant zoom link and supply list at least 1 hour before each drop-in group started. The required materials included drawing materials (e.g. pens, pencils, colored pencils, markers, highlighters), computer paper and or drawing paper, old magazines/newspapers, scissors, a glue stick, and a small box (e.g. old shoe box, tissue box, cardboard box, Tupperware container, etc.). The small box was only required for the first group on December 8<sup>th</sup> and was optional but encouraged for the second group on December 16<sup>th</sup>. The optional materials for each group included, acrylic paint, watercolor, mod podge, and paint brushes. These materials were selected based on common materials that people may already have in their home. Participants were encouraged to get creative through using non-traditional materials (i.e. nature, nail polish, newspaper, highlighters) and were not pressured to buy any new materials for the groups. Participants were encouraged to engage in the art therapy interventions, but were not excluded from the group process if they chose just to listen. Since, this group was created as a space for clients with ED to connect with others in recovery during a difficult time of year. The art therapy intern would problem solve with participants who may have had limited or no art materials so that they could still engage in the art therapy interventions. For example, one participant did not have any traditional art materials and did not feel comfortable creating art so they journaled and made lists in response to the art therapy interventions. This participant was still able to engage in the group discussion and process despite not making any artwork. Overall, while it was strongly encouraged for group members to

engage in the art therapy prompt the previously stated goals could still be achieved for participants even when they did not fully participate in the art making process.

### **Procedure**

My method engaged adults with eating disorders in art therapy interventions via a virtual 4-week peer support drop-in group. These groups used psychoeducation and art therapy interventions to help participants struggling with an ED navigate the holiday season. More specifically these groups were created to help clients with EDs navigate the abundance of food, conversations with family and friends about weight and diet culture, and cope with heightened pressures or expectations from the media and those around them about weight and health. These groups also offered clients an opportunity to connect with others who have similar experiences to help decrease feelings of shame or guilt. These 60-minute virtual drop-in peer support groups occurred every Tuesday evening from 5-6 pm (EST) from December 8<sup>th</sup> – 29<sup>th</sup> 2020. Each of the 4 groups incorporated a different theme. The following four themes were selected for the groups and are listed in chronological order of how each theme was introduced for each group; creating a safety plan, body image during the holidays, self-advocacy/our inner critical voice, and talking back to diet culture. These four themes were chosen based on common challenges and triggers that clients with EDs face during the holiday season. The topic selected for each group was created to help clients identify potential triggers, normalize any fears or feelings of shame they may be experiencing around these triggers, and ways to with cope difficult emotions that they may experience. Each of the four identified workshop themes used one of these corresponding art-based interventions such as creating a coping skills toolbox/bailout plan, creating an inner and outer box or collage, creating a 3D safety corner, and a hopes and goals for recovery collage.



These four art therapy interventions are listed in chronological order and correspond to the order of the group themes.

The first group theme of creating a safety plan was created to help clients explore and identify potential challenges or triggers they may face during the holiday season. For example, group members were asked to reflect on where and who they might be eating with during their respective holiday; if they would be exposed to conversations about diets, weight, calorie numbers, or exercise; if they would be around fear foods; if they would need to prepare fear foods for their family or if they would be the sole person making their families holiday meal and if covid was impacting their holiday plans (i.e. not getting together with family or friends). To help participants alleviate and cope with their increased anxiety that may result from participants experiencing these challenges they were asked to create a coping skills toolbox. This toolbox was a tangible way for participants to proactively plan ahead for how they could support themselves when experiencing symptoms of anxiety or depression (see Appendix E). The toolbox included a coping skill for each of the five senses; sight, smell, sound, touch, and taste. Participants would choose either the actual coping skill or something that represented the coping skill. For example, a client may choose to include a bottle of lavender essential oil for smell to help them relax. Or a client may choose to include a picture of a trusted friend for sound to remind them to reach out to when needed instead of isolating. This art therapy intervention allows participants to develop coping skills, distress tolerance skills, and increase self awareness.

The second group theme of body image during the holidays was implemented to help participants explore messaging that Western culture portrays regarding body weight shape and size such as thinner being better and healthier. This group topic was also intended to help participants discuss with each other about negative messages we receive from the media around

weight gain during the holiday's and weight gain during covid. The facilitators wanted to be able to provide participants with the opportunity to connect with others and gain skills in how to set boundaries with others regarding comments they may receive around their body size and food choices. The inner and outer box was designed to help participants identify how they view themselves on the inside and how they either present themselves to others or how they believe others perceive them (see Appendix F). This art therapy intervention was designed to increase participants self-awareness, self-esteem, and boundaries through identifying their inner strengths and areas of growth.

The third group theme of self advocacy and our inner critical voice was created to help participants identify their negative thought patterns or inner critical voice (see Appendix G). Participants were encouraged to reframe their thinking and imagine their inner critical voice was coming from a 4 year old version of themselves that was afraid and may not be getting a certain need(s) met. Group members engaged in a psycho educational discussion on their inner critical voice and how to access and use the nurturing parts of themselves to tend to their mental, emotional, physical, and spiritual needs. The group discussion explored how our critical voice can manifest from our fears such as not feeling good enough or feeling afraid of being excluded by others. Participants were asked to close their eyes and take a moment to access their inner nurturing self by imaging a person real or imagined who is loving and kind to them. During the guided meditation participants were encouraged to think of what it felt like to be loved by that person or being and how that may have made them feel secure and safe. This group topic and discussion was used to help clients increase their self awareness, self esteem and coping skills through identifying and challenging their inner negative thought patterns. The art therapy intervention used for further exploration of this group topic was to create a 3D safety corner (see

Appendix G). Participants were given instructions on how to assemble the 3D safety corner using a square piece of computer paper. Group members were then encouraged to draw their safe space within this safety corner. They could chose to create a scene of a particular space or place they find to be safe or people, place, things or coping skills that help them to feel safe. Similar to the group topic this art therapy intervention was designed to help participants increase their self awareness and coping skills through identifying what safety means to them and what safety feels like for them when their needs are met. Participants were encouraged to keep their safety corner in a place they frequent as a reminder of the people and things that help to ground them.

The fourth group theme of talking back to diet culture was created to facilitate a conversation on ways participants could navigate weight, food, and diet talk during the holidays. Some of these topics were discussed during previous groups however participants were not required to attend all the groups and could join in the groups at any point during the four weeks. The two facilitators of these groups thought that by having the last group focus on practical tips for navigating difficult conversations with friends and loved ones would be most beneficial for participants. Especially for those who may have missed the previous groups. This group in particular was designed to offer a space for participants to receive support and process previous negative conversations they may have had with friends and family during the holidays regarding weight, food, and diet talk. The facilitators offered the participants a psycho educational discussion on healthy boundaries (see Appendix H). For example, setting clear limits with others, saying no, valuing your own opinion, not compromising your values for others, only sharing personal information at your own comfort level, identifying your wants/needs and how to communicate your wants/needs, and leaving a conversation or room when necessary. To compliment this theme and to honor the group ending the art therapy intervention was a hopes

and goals for ED recovery collage. Participants were encouraged to think about their identified boundaries and how respecting and honoring those boundaries can influence their specific intentions, hopes or goals they may have for their eating disorder recovery. For example, a person might value honesty therefore a potential goal for their ED recovery would be to communicate their needs to others in order to feel safe and respected for their choices. Participants were encouraged to hang their collages in a spot they frequent as a form of encouragement when choosing their ED recovery feels challenging. This collage could also be used as a artwork to reflect back on to in order for the individual to identify progress in their ED that they may have made.

A link for registering for the groups was located on the Outpatient Eating Disorder Treatment Clinic's calendar webpage. All participants signed a digital participation liability waiver when signing up for the group. All of the drop-in peer support groups were free. The groups were co-led by two graduate clinical interns which included an art therapy intern and a social work intern.

The general outline for each group included a review of the ED treatment centers group guidelines and group members checked-in (i.e. name, pronouns, reason for coming to group). This process would take about 10 minutes. After check-ins were complete, the two group leaders would provide the group members with a general overview of the group itinerary for that hour and would introduce the particular topic of that group. The social work intern would facilitate a psychoeducational discussion on the identified topic for that group. She would encourage group members to engage in a dialogue about their experience and thoughts on the topic. The duration of the psychoeducational discussion would take about 10-15 minutes. This discussion would transition into the art therapy intern introducing and explaining the art therapy intervention for

that group. Group members would have between 20-30 minutes to engage in the art therapy activity. Group members were encouraged to put themselves on mute and play music independently as they created their artwork. Group members were also encouraged to ask questions or make comments to the group during their creative process if something came to mind.

The art therapy intern facilitated a discussion with group members about their experience with the art therapy prompt, their creative process and what they created. This discussion would lead into the group check-out facilitated by both interns. These two final sections of group would take about 10-15 minutes. Group members were encouraged to identify how they were feeling in one word, if their participation in group helped their overall mood, and/or any takeaways from their experience in group.

### **Data Collection and Analysis**

Information was collected and recorded in a journal documenting poignant moments from group, this writers' internal reactions during and after the group, and group members check-out responses. This collected information was then typed into a word document organized by each group. This writer also created reaction artwork in response to each of the four groups. The reaction artwork was created directly after each group, for approximately 30 minutes. Once all the data was gathered, this writer identify a theme that stuck out to them based on this writers reactions of each group, participants responses, and this writers art responses.

### **Results**

In total over the four group sessions there were 36 participants and 3 participants were in attendance at each group. All participants identified as female except for 1 participant in the fourth group who identified as non-binary. The collected observations will be presented for each

group session individually. In each group session summary the total number of participants will be identified along with this writers reactions and observations, and a summary of the art responses created by this writer. Based on all of this identified information documented during each group this writer will now discuss the identified themes that were present in the collected data and how this data relates to the literature reviewed.

### **Observations**

**Group 1.** There were 11 participants who attended the first group. At the start of group participants presented as a mixture of euthymic, excited, and anxious as evidence by their relaxed or closed body language, direct eye contact, and smiling. The group appeared to build some rapport amongst eachother by the middle of the group as indicated by participants laughing and smiling with eachother. Participants were invited and encouraged to check out of the group by saying one word about how they were feeling. Some participants chose to say a statement as opposed to one word. These groups were voluntary therefore participants were given the option to say “pass” if they did not want to share a word about how they were feeling. Notable check outs shared by participants during check out included; “I feel happier and better than before”, “this group is a nice option to come together with others during covid times”, “purposeful...worked hard to be in the moment”, and “anxious”. Overall, the participants observed behavior during group and their check out responses indicate participants feeling better than they did at the start of group due to the making connections with others. This facilitator’s art response tried to captured the positive experience that participants expressed by attending the group (see Appendix A). The collage the facilitator created highlighted the connections group members were able to make through creating art together. This art response also captured the facilitators felt sense by group members that these groups would become a safe space for

participants to come together to build connections, receive support, and decrease isolation. Based on the collected data for this group, participants overall mood and affect increased due to the opportunity for connection and a sense of community with others in ED recovery that this art based group provided.

**Group 2.** There were 9 participants who attended the second group. At the start of group the returning participants presented as a mixture of euthymic and excited as indicated by their relaxed body language, direct eye contact, and smiling expression. New participants presented as calm and anxious as evidenced by their closed body language, indirect eye contact, wary expression, and some fidgety behavior. All group members came prepared to group with the identified collage materials and therefore appeared as actively committed in the group process. Despite one week having passed rapport among returning and new members appeared to be present through a returning group member sharing their ED recovery scrapbook with the group and fellow group members responding with positive feedback. This particular group member also chose to create her inside and outside collage in her eating disorder recovery scrapbook. Notable comments made by participants during check out included “I am grateful, glad to be here...enjoyed the collage...feels good to be creative”, “liked collage”, and “making space for being creative”. The personal nature of this inside and outside collage prompt encouraged group members to practice vulnerability through identifying how they feel on the inside and how they present themselves to others. Holding space for this vulnerability is a theme present in this facilitator's art response (see Appendix B). The imagery in this art response includes a variety of tranquil spaces and warm light. This imagery reflects the sense of safety and trust that group members felt amongst each other. Based on the collected data for this group a theme that

presented itself was using art as a way to build safety, vulnerability, and rapport among group members.

**Group 3.** There were 8 participants who attended the third group. Similar to the first two groups participants presented as both euthymic and excited as indicated by their relaxed body language, direct eye contact, and smiling expression. New participants presented as calm and anxious as evidence by their closed body language, indirect eye contact, and wary expressions. All group members actively engaged in the art therapy intervention and group discussion. Notable comments made by participants included; “I really liked the safety corner and want to put my safety corner on display.... I feel good after group”, “happy to divert attention to art making”, “got me out of my head”, “really enjoyed, helpful for later”, and “good to have reminder that [I] can do good things for myself”. During this particular group this facilitator internally identified feeling more confident leading group due to group members being able to hold a conversation amongst themselves with less guidance by the facilitator. This observation is reflected in the facilitators art response through figures in the image extending off the page (see Appendix C). There is a pause button drawn on the image to represent the participants feedback that the group provided them with a safe space to receive support and practice self care during a triggering time of year. Overall the image appears cohesive and connected which parallels the rapport among participants and cohesive group flow. Based participants responses their self esteem, self awareness , and pride increased through the group process. The art therapy intervention allowed clients an opportunity to redirect their attention to things or coping skills within their control that they could use to feel a sense of safety and comfort.

**Group 4.** There were 8 participants who attended the fourth group. Similar to the first three groups participants presented as both euthymic and excited as indicated by their relaxed



body language, direct eye contact, and smiling expression. New participants presented as calm and anxious as evidenced by their closed body language, indirect eye contact, and wary facial expressions. Some participants did appear more glum and wary when compared to previous groups as indicated by slouched body language, sad demeanor, and inconsistent eye contact. This presentation by participants may have been related to the fact that this was the last group in the series, that this was the group right after Christmas and right before the New Year, and that the group topic was related to group members identifying their hopes and goals for their ED recovery. One internal observation that this writer wrote down during the group was that there was a heaviness present in the group. Notable comments made by participants included; “feeling more rooted in my recovery”, “first time identifying my ED recovery”, “really liked that art activity and feel less anxious”, “I feel bewildered in my recovery”, “recovery feels far away right now”, and “reflective”. One group member identified not knowing what their hopes and goals for recovery were. Overall this writer had a felt sense that group members were struggling with the ambivalence of their ED recovery which is captured in the blank space of this facilitator’s art response (see Appendix D). There is a long water droplet in the art response reflective of group members hesitation and anxiety about pursuing eating disorder recovery. The image as a whole appears contemplative and unknown which parallels participants’ comments during group. Based on the data collected, the theme of ambiguity in ED recovery was present.

Observations of the client’s behaviors during each of the virtual art therapy groups revealed their engagement in the process as evidenced by their interest in group themes and their engagement in the art therapy prompts. The combination of psychoeducation and art therapy interventions used in each of the drop in groups seems to have engaged and provided momentary psychological relief for the clients. The collected information from the 36 participants as it

related to the group members check-out responses at the end of all of the groups indicated members feeling happier, anxious, joyful, grateful, appreciative of having a distraction, and or sense of connection to fellow group members. Overall from the relevant data collected from this four week series that used art therapy as the primary therapeutic intervention participants received the following benefits; increased sense of connection/community, increased rapport, increased coping skills, increased self esteem and increased self awareness regarding the role of ambiguity in ED recovery.

### **Discussion**

These virtual four-week peer support groups incorporated aspects of evidence-based ED treatment to expose clients to themes and concepts to either elicit their ED treatment or support their current treatment. These groups were not designed to be an immediate fix for clients, but to offer temporary psychological relief in the moment and to support existing evidence-based treatment that some participants may have been receiving in individual therapy or through other outpatient mental health resources. The facilitators of the four groups integrated common themes and interventions used in evidence-based eating disorder treatment and integrated these treatment approaches with art therapy interventions. The results reported above are based on the writer's experience and impressions while working with 36 clients with EDs in a virtual ED outpatient treatment setting. The current literature continues to provide evidence that art therapy can help elicit and enhance the therapeutic process for clients with EDs. As previously identified in the results section, I identified themes that presented themselves through participants engagement in the art therapy based groups. Such themes include; increased sense of connection/community, increased rapport, increased coping skills, increased self esteem and

increased self awareness regarding the role of ambiguity in ED recovery. These themes and the previously reviewed literature will be explored together below.

**Community, Connection, & Rapport.** All four of the virtual peer support groups incorporated psychoeducation, coping skills, and mindfulness within the context of art therapy into the group curriculum. As one client shared during the first group, the group was “a nice option to come together”. The groups provided clients with EDs an opportunity to learn about the purpose that their ED behaviors serve while connecting with others who “get it”. Psychoeducation can provide a client with an ED the opportunity to understand their ED diagnosis and the ways in which their maladaptive coping strategies or behaviors cause harm (Belak, 2017). Providing psychoeducation in a group setting allows for clients to connect with others who have similar experiences which helps to decrease feelings of shame and isolation for clients. Having clients come together in a group setting and use art materials helped motivate individual clients to try different coping skills and mindfulness-based techniques that they may otherwise have found to be too threatening or challenging for their inner ED voice. This group art therapy setting also provided these clients with a sense of accountability. Participants were able to witness the creative process of other group members pursuing their ED recovery and the challenges and triumphs present within that process. By participants engaging in the creative process they were able to shift their attention away from their ED behaviors and focus on connecting with others allowing strong sense of rapport to develop among group members.

**Self Esteem & Self Awareness.** Participants had an opportunity to explore and share their values, preferences, and characteristics in relation to their ED recovery through each of the art therapy interventions. By designing the art therapy interventions to prioritize the values, preferences, and characteristics of the participants this made the topics more relevant and

approachable for participants. For example, the coping skills toolbox/bailout plan provided clients with an opportunity to identify coping skills related to their 5 senses that work for them. When creating the inside and outside collage clients were able to express their values and characteristics through identifying values of their core self and how they believe others view them. Clients had an opportunity to identify their preferences through creating the 3D safety corner where clients were asked to create an image of a safe space. As Wolf et. al. (1985) identified artwork created by a client becomes as tangible item they can see, hold, and identify their feelings with. One client expressed that they “really liked [their] 3D safety corner and wanted to put [their] 3D safety corner on display” as a reminder of what brings them a sense of safety. For this participant, providing them with the opportunity to chose what makes them feel safe was empowering and meaningful enough for them to want to be reminded of whay they created. Given the purpose of the 3D safety corner this participant increased their self awareness through identifying what makes them feel safe and increased their self esteem through creating something they were proud of and wated to display.

For the last group clients used their values, preference, and characteristics to create a selfcare collage of their hopes and goals for their ED recovery. One notable comment made by a client during the last group was that they “[felt] more rooted in [their] recovery” after creating the collage. As Hinz (2006) suggested the art making process allowed this participant to identify with their recovery in a positive manor through them identifying their hopes and goals for their ED recovery. The participants process of creating the collage and identifying their hopes and goals increased their self awareness. The participant also increased their self esteem through having a positive experience creating their collage and thus relating to their recovery in a positive manor through enjoying this experience. All four of the virtual peer support groups provided clients with

an opportunity to engage in themes of their ED recovery in a nonthreatening way through art making. Using art therapy interventions created an environment where group members were able to safely explore their difficult emotions and feelings non-verbally. Thus decreasing the risk of clients jumping to use their defense mechanisms when they actively moved towards ED recovery and something threatened their ED behavior use (Bucharová et. al., 2020).

**Ambiguity.** As Fursland (2012) highlighted understanding the role of ambivalence in the therapeutic process for a client in ED treatment is essential in order for the client to feel supported enough to step outside their comfort zone. As a clinician, it is a part of one's role to help the client to practice sitting in the discomfort of difficult feelings. This became apparent during the last group when clients were asked to create a collage of their hopes and goals for recovery. One client mentioned their collage made them realize that "recovery [felt] really far away right [then] and another client identified not even being able to identify their hopes and goals for recovery." While talk therapy alone may have allowed these clients to identify their feeling associated with their goals of recovery creating their collage allowed them to feel their feelings associated to their recovery (Bucharová, 2020). Inviting a client in ED recovery to admit that they have an ED and are actively pursuing recovery can cause the individual to experience a variety of difficult emotions leading to a potential sense of ambiguity.

Based on the variety of responses we received during the groups, the participants in the groups were in a variety of the stages of change which likely influenced their readiness to be able to identify their hopes and goals for recovery. For example, the participant who shared that they were unable to identify their hopes and goals is likely in the precontemplation or contemplation stage of change. The art therapy prompt of the fourth group invited clients to engage with an aspect of their ED that involved them needing to be self aware of where they are in their ED recovery and

identifying that are ready to pursue recovery which is not an easy task. Based on the responses of group members such as “it is good to have a reminder that I can do good things for myself” and “this is [my] first time identifying the hopes and goals of my ED recovery”. Clients were either in the precontemplation, contemplation, or the preparation stage of change. This theme of ambiguity is important to highlight because it is an aspect of ED recovery that can be difficult for clients to identify, explore, and understand through talk therapy alone. Ambiguity can be better understood through feeling the feeling as opposed to just identifying the feeling (Bucharová, 2020). As the participants in this group experienced the art making process allowed them to identify and feel the feeling of ambiguity increasing their self awareness and insight.

**Implications Based on Findings.** Based on these findings art therapy could be a beneficial addition to include in evidence based treatment practices for clients with EDs. As mentioned previously these groups were not designed to be an immediate fix for clients, but to offer temporary psychological relief in the moment and to support existing evidence-based treatment that some participants may have been receiving in individual therapy or other out patient mental health resources. Through the integration of art therapy and evidence based ED treatment approaches benefits that presented themselves in this four week program include the following. The art therapy interventions increased participants sense of connection/community, increased rapport, increased coping skills, increased self esteem and increased self awareness regarding the role of ambiguity in their ED recovery. While this paper supports the idea that art therapy can help to decrease the rate of relapse, increase treatment retention, and increase the number of clients who achieve full ED recovery further research is needed in order to prove the validity of this claim.

**Limitations.** Given the nature of the method of this thesis there are several limitations that should be noted. First, there is an increased likelihood that this writers bias are present in the

thesis due to their lived experiences and clinical experience to date influencing their perspective and understanding of participants engagement in the four groups. The participants in the four groups are not generalizable to the general public because the participants all identified as female except for one participant who identified as non-binary. The participants in these groups were also predominately white and further research would need to be conducted with clients of all races and ethnicities. Additionally, since this was not a formal research study there was no control group included in the research design of this thesis thus decreasing the validity of the data collected. There was also inconsistent attendance across all groups therefore the facilitators can not say for sure if the groups provided a significant psychological relief for the participants who attended group. As mentioned previously, the groups were only an hour long and occurred 4 times over a 5 week period which makes up a small fraction of time for someone receiving out patient support in their ED recovery. Given that the four groups occurred in an online format there was no way of controlling the environment that each participant was in. Therefore there could have been potential distractions in the background while participants were engaging in the art therapy intervention thus potentially altering their experience and the data collected.

**Conclusion.** Art therapy alone is not considered an evidence-based treatment method for treating clients with EDs. Additionally, a standardized treatment method for using art therapy with clients with EDs does not exist. Based on this writer's review of current ED literature no studies to date have researched the use of art therapy for the treatment of EDs in an outpatient treatment setting. The ED literature reviewed for this paper highlighted evidence-based ED treatment methods used in residential or partial hospitalization programs. The evidence to date strongly substantiates further explorations of art therapy with clients with EDs in an outpatient setting, which is necessary for clarification on appropriate approaches when working with this

population. Future studies should extend to a greater variety of identities as current ED research mostly examines cis-white women. With further research and creative approaches, the use of art therapy to elicit and enhance the treatment for clients with EDs in an outpatient setting could greatly increase and become a part of the evidence based ED treatment currently used. One way in which art therapy could become a part of evidence based ED treatment is through incorporating formal or informal art therapy assessments such as the bridge drawing. The bridge drawing could be used at any point in a client's ED treatment to help the clinician and client understand where they identify themselves in their recovery process and where they would like to go. Additionally conclusions drawn from administering formal and informal art therapy assessments to clients with ED could be used to better support and enhance the existing interventions and treatment approaches used by the clients treatment team. As ED treatment become more accessible to a greater variety of clients this writer hopes the role art therapy of within ED treatment will continue to expand as well.



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## Appendix

## A. Group 1 Personal Art Response



## B. Group 2 Personal Art Response





## C. Group 3 Personal Art Response



## D. Group 4 Personal Art Response



E. *Week 1 (12/8): Safety Plan (Art based activity: Coping Skills Toolbox)*

- As participants arrive to zoom link check in to make sure all participants have their art supplies prior to group starting
- Review Group Guidelines
- Check-ins
  - Name, Pronouns, & briefly describe what made you decide to participate in this group? What are you hoping to get out of this group? If you want to include where you are from, you can as well.
- Introduce Topic / Psychoeducational Discussion - 10 min
  - **Coping with the Uncomfortable Feelings and creating a safety plan** (the eating disorder behaviors are coping mechanisms to feel in control, comfort, etc.)
  - Eating disorders are WAY more than food, diet, and weight.
- *Plan ahead* so that you are able to keep up with your normal meal plan and treatment plan as best you can. *Do not restrict* leading up to (or after) an event. If you are concerned about purging during or after a party, let your therapist (or support partner or a trusted friend) know ahead of time, *put a safety plan in place*, and check in with them if urges come up.
  - Questions you can ask yourself to help assist in creating your safety plan: Are you upset about something? Stressed out? Feeling lonely? \*identify the emotion then choose a positive alternative coping mechanism such as call a friend, take a walk, draw, take a bath, write in a journal, etc.
  - Knowing your triggers and making a list of them/identifying coping skills to manage them in an effective way
  - Helpful coping statements/mantras (examples: “Being more flexible with food allows me to have a full life.” “Being scared in recovery is normal, but I don’t have to let that fear control my actions.”)
- Art Therapy Intervention– self soothing techniques Coping Skills Toolbox / Bailout Plan - (20 min)
  - a) Start by creating a list of coping strategies that you may already use to help you cope with stress. You may choose to create this list specifically for the coping skills you will use to support your E.D. recovery this holiday season. You can include new coping skills that you want to try.
  - b) **Pick 5 coping strategies from your list that relate to each of the 5 senses- sight, sound, taste, touch, smell.** You can refer to the ‘5 Senses Coping Skills Worksheet’ (share screen)
  - c) If accessible you can choose to gather 5 objects that represent each of the 5 coping skills you have identified. If not, accessible you can write down what they five objects are. You can choose an object that is the actual coping strategy or chose an object that represents the coping skill. Get creative!
    - i) Example: Using essential oils may be your smell-based coping skill. So, you could include a bottle of your favorite essential oil in your 5 objects.

- ii) Example: Calling a close family member or friend may be your sound-based coping skill. So, you could include a picture of this person as one of your five objects. The picture would serve as a reminder for you to call this person when you are stressed.
  - d) Once you have identified all your objects you can start creating your container that will hold your 5 objects (share screen – coping skills toolbox examples). We encourage everyone to keep their box in a space that they frequent as a reminder that you have these supports in place. You will have about 15 minutes to create your toolbox.
    - i) You may choose to decorate your box with inspirational quotes/mantras, pictures, collage images, serene or peaceful images, the box can reflect your interests, etc.
- Discussion/Response to Art Therapy Intervention - 5 min
  - Your safety skills toolbox can be used as your Holiday bailout plan
  - Depending on # of participants and time left participants can share their container, a coping skill they chose, or their experience of the creative process
  - These boxes are a great to bring to therapy to explore more. Please feel free to continue to work on your coping skills toolbox after group if you need additional time.
- Closing- 5 min
  - One word to describe how you are feeling right now

**F. Week 2 (12/15): Body Image During the Holidays (Art based activity: Inner and outer box)**

**\*identifying triggers, supports, and be proactive about what you need (identify where triggers lie and how to move forward)**

- As participants arrive to zoom link check in to make sure all participants have their art supplies prior to group starting (who has a box and who has paper?)
- Review Group Guidelines
- Check-ins - 10 min
  - Name, Pronouns, & briefly describe what made you decide to participate in this group? or if you have participated in this group before one word to describe how you are feeling today
- Discussion/Psychoeducation: *Holidays can be complicated for people struggling with eating disorders, disordered eating, or body image issues. For those who struggle with body image, the focus on food and family gatherings around the holidays may create anxiety.*

- Facilitate group discussion on identifying your triggers.  
You may find that these triggers occur before deciding to engage in an ED behavior
  - What are some of your body image triggers?
  - What are some of the feelings that follow or accompany a trigger?
  - Where do you feel this trigger in your body?
- Review Mindfulness and Self soothing techniques (DBT skills)
- *Mindfulness* can also help with noticing and acknowledging negative thoughts around body image.
- (Refer to last week) Using *self-soothing* techniques (using your senses to provide comfort for yourself) When you think about self-soothing techniques, what comes up for you? Take the time to discuss different self-soothing skills (i.e. going for a walk to see nature, listening to music, eating a sour piece of candy, taking a hot bath, etc.)
  - Mantra notecards & phone notes
- Art-based Activity - Inside Outside Self - 20 min
  - Our E.D. can greatly distort our perception of self and how we perceive others view us especially when it comes to body image concerns. While identifying these perceptions will not make them magically go away identifying these perceptions can help us to become more aware of our thought patterns and reactions to them.
  - Cut out different words and/or pictures from magazines/newspapers that represent how you believe others view you. Glue them into a collage on one side of the paper (if using paper label each side of the paper) or outside your box/lid
  - For the inside of the box, you will repeat the same process using different magazine pictures and/or words. One the inside of the box you will focus on how you see your true self and identity. (share screen- *Inside Outside Self* participant instructions)
- Discussion/Response to Art Therapy Intervention - 5-7 min
  - Instruct everyone to look at the outside of their box/paper, observe the words or images you have selected.
    - Eating disorder voice vs. Rational self (your ED voice may be louder right now and it can be helpful to be proactive and prepped for moments when you are triggered).
    - **You may find that some of the words or images that you selected for the outside of the box may not make sense rationally or even contradict how you truly see yourself. Sometimes are perception of what we think others think of us is not always accurate or within our control.** Are there any words or images that stick out to you? Do any of the words or images contradict each other?
  - Due to time, we do not have time to do an in-depth reflection on your boxes/ collages you have created. However, some additional questions to consider include:



- How does it feel to look at the outside of your box in comparison to the inside of your box?
- Is there anything you would change or add to the inside or outside of your box/ paper?
- Was the inside or the outside easier to create? What about that particular side made it easier/harder?
- These boxes/collages are a great to bring to therapy to explore more. Please feel free to continue to work on your box/collage if you need additional time. You may also choose to write a short free write in response to your box/collage and/or your experience of your creative process today.
- Closing
  - One word to describe how you are feeling right now & one thing you will do today that is positive for your recovery

**G. Week 3 (12/22): Self-Advocacy/Critical Voice (Art based activity: Create Safety Corner)**

- As participants arrive to zoom link check in to make sure all participants have their art supplies prior to group starting
- Review Group Guidelines
- Check-ins
  - Name, Pronouns, & briefly describe what made you decide to participate in this group? What are you hoping to get out of this group? or if you have participated in this group before one word to describe how you are feeling today
- Discussion/Psychoeducation (15 minutes)

Our critical voices are one of the ways fear expresses itself in our lives. Think about something your critical voice says to you. Now imagine that that voice is coming from a scared four-year-old child who desperately wants your attention. Instead of giving this little child who is having a screaming tantrum power by trying to run away from them or making them stop talking (which generally makes a fearful child yell louder!), imagine what it would be like to turn towards this little being, pick it up, and find out why it is afraid. Chances are the child inside of you who is being mean and wants you to perfect yourself in some way is just afraid of being hurt or vulnerable. When we can see that these critics, our fear voices, are trying to protect us in some misguided way, we can more easily get to the essence of what we are afraid of and address the issue head on, recognizing that beating ourselves up doesn't serve any useful purpose.

- Raise your hand if you've ever had critical thoughts about your body or other parts of yourself? Have you ever shared these thoughts out loud to others?

- Our critical voices are really just fear talking to us. Mean things that are said to us often get inside our heads and become our own mean voices. You might want to think about your critical voice as a little kid inside of you who is having a tantrum and wanting to have attention because they are afraid of something. Our critical voices really just want to protect us, but they don't know how to do it in a nice way.
- Critical voices come from our many fears, like the fear of being excluded from friend groups, or the fear of being teased for how we look or act. The goal with this activity is to come up with a way to let our fearful little selves be heard and give them lots of love so they can be quiet and not yell at us.
- **To access this nurturing part, let's first take a moment for you to close or soften your eyes (or have a soft gaze), and breathe into every cell in your body. Now contact a place inside yourself of feeling connected to a person or other being who is loving and kind. It might be someone from the past or someone you know now, someone alive or someone who is no longer here. It might even be a pet that loves you and is happy to see you, or a spiritual being to which you feel connected. What does it feel like to be loved by this person or being?** Now get a sense of feeling safe where you are right now. Knowing that your nurturing part is caring for you, let your body and mind know that it is safe to be vulnerable during this activity. Remember that you have the capacity within you already to choose love over fear.
- **Art-based Activity : Create Safety Corner (15 min)**
  - You are now going to create a 3D version of this safe space you have imagined
  - Demonstrate how to fold the safety corner (5 min)
  - You may now use any drawing materials you have to draw what your safe space looks like and what objects or people may be there. Feel free to add in any words or mantras that resonate with your feeling of a safe space. You may choose to include objects or things that help you to feel grounded.
- Discussion/Response to Activity
  - Encourage group members to share their safety corner with the group.
  - What was the process like to use a guided meditation & create a piece of artwork based on your visualization?
  - We encourage you to keep these safety corners in a spot you frequent in your home as a reminder of the things that help ground you.
- Closing
  - One word to describe how you are feeling right now & one thing you will do today that is positive for your recovery

#### H. *Week 4 (12/29): Talking Back to Diet Culture (Art based activity: Self Care Collage)*

- As participants arrive to zoom link check in to make sure all participants have their art supplies prior to group starting
- Review Group Guidelines (**3 min**)
- Check-ins - 10 min
  - Name, Pronouns, & briefly describe what made you decide to participate in this group? or if you have participated in this group before one word to describe how you are feeling today
- Discussion/Psychoeducation: Navigating Weight/Food/Diet Talk During the Holidays: 10-15 minutes)
  - Validating the feeling, not the diet culture “I’m so happy you are happy.” \*not complimenting a person’s weight loss or body/appearance in general
  - Empowered- “I’ve actually found that not being so focused on my weight has made me way less stressed-something I really needed during this pandemic going on!
  - Be real- “Ugh, diet culture is so boring!”
  - Educate (but remembering that it isn’t our job to change their minds)
  - Boundaries (setting clear limits for and with someone)
    - How can we set healthy boundaries?
      - Start by using your voice and saying “No”
      - Value own opinions
      - Don’t compromise your values for others
      - Share personal information at your OWN comfort level
    - Know your wants, needs, and how to communicate them
    - Can always leave the room

*\*Access your mental and emotional state before going into a conversation*

***\*Your body, your weight= NOT up for a discussion***

*\*You are allowed to opt. out of conversations where a boundary has been crossed*

- Art-based Activity: Hopes & Goals for Recovery Collage - (15 min)
  - Keeping in the mind the boundaries you have identified begin to think about what some of your hopes and goals for recovery are. Apart of the process of being able to honor and respect our boundaries is identifying specific intentions, hopes, or goals we may have for our recovery. If we are able to create specific intentions, we have about our recovery process this can help inform our boundaries
  - You may think of things you value in life. How do these values inform specific hopes or goals you may have for recovery?
    - For example, a value of yours could be honesty therefore, a goal for your recovery may be to communicate your needs to others. This might require you to practice being vulnerable with your loved ones.
  - Cut out words and images that reflect your hopes and goals for recovery and collage these images onto your paper

- Discussion/Response to Activity (**10 min**)
  - What are some of hopes and goals you identified? Encourage participants to share their images if they feel comfortable.
  - In what ways do your values inform your hopes and goals?
  - We encourage you to hang these collages up in a spot you frequent as a form of encouragement during your recovery and for extra support during the holidays. Maybe you will keep the collage on your bedside table, in your car, in your planner/journal, or inside a kitchen cabinet. Do what makes the most sense to you.
- Closing
  - One word to describe how you are feeling right now & one thing you will do today that is positive for your recovery

***THESIS APPROVAL FORM***

**Lesley University  
Graduate School of Arts & Social Sciences  
Expressive Therapies Division  
Master of Arts in Clinical Mental Health Counseling: Art Therapy, MA**

**Student's Name:** Miranda Hays

**Type of Project:** Thesis

**Title:** Exploring Art Therapy with clients suffering from Eating Disorders in an Out-Patient Setting

**Date of Graduation:** May 22, 2021

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

**Thesis Advisor:** Raquel Stephenson, Ph.D, ATR-BC, LCAT